

Psychiatry

T.me/alltebfamily

Definition *Psychiatry is that branch of medicine that deals with the study & treatment of disturbances of thinking, emotions & behavior. These symptoms may be secondary to functional or organic causes.*

Classification of Psychiatric disorders:

1. Neurotic, stress related & somatoform disorders:

-Anxiety disorders:

Generalized anxiety.

Panic disorder.

- Obsessive compulsive disorder (OCD)

- Dissociative conversion disorder (Hysterias)

- Somatoform disorder

- Phobic anxiety disorders.

- Post traumatic stress disorders.

2. Schizophrenia & delusional disorders.

3. Affective (mood) disorders:

- Depression.

- Mania.

4. Organic:

- Acute e.g. delirium.

- Chronic e.g. dementia.

5. Behavioral syndromes:

- Eating disorders

- Sleep disorders.

- Sexual dysfunction.

6. Personality disorder.

Old classification:

Neurosis	Psychosis
<i>In which the patient may suffer & finds difficulty in adjustment & adaptation but in normal contact with reality</i>	<i>It is severe mental illness in which there are personality changes, impaired perception, disturbed thinking & impaired insight.</i>
1. Insight (present)	1-No sight
2. No deterioration of personality	2-Personality deterioration
3. In contact with reality	3-Loss of contact with reality
4. No or little disturbance in thinking	4-Disturbed thinking
5. No perceptual disorders.	5-Present e.g. hallucination
6. Intact orientation.	6-Lack of orientation
Examples; anxiety, OCD	

VISIT...

LANZAROTE
Caliente.COM



examples: affective disorders & schizophrenia

Anxiety disorders

(Generalized Anxiety)

It is a subjective feeling of fear or apprehension usually accompanied by autonomic system hyperactivity & physical discomfort.

NB: Anxiety is a normal emotion which in a moderate degree can be a helpful force by increasing effort & alertness. It is also protective function in the face of danger. It becomes pathological when symptoms are out of proportion to external circumstances or if persist long after a threatening situation. Also normal anxiety is less severe & of longer duration than pathological anxiety. Lastly normal anxiety improve performance but pathological anxiety decrease it.

Types & Differential diagnosis:

- Normal Anxiety it is a universal feeling, see above.
- Anxiety neurosis.
- Anxiety symptoms secondary to other psychiatric diseases
e.g. depression, hysteria, schizophrenia, mania.
- Anxiety secondary to medical diseases:
e.g. thyrotoxicosis, pheochromocytoma, cerebral atherosclerosis, mitral valve prolapse, hypoglycemia, angina, bronchial asthma, alcohol & drug withdrawal.

Etiology:

- 1- **Heredity:** increase rate among twins.
- 2- **Learnt response:** child learn to be anxious in situations which they experience as threatening.
- 3- **Physiological basis:** increase level of catecholamines
- 4- **Psychological basis:** A continuous conflict which pushes the individual beyond the last limit of adaptation.
- 5- **Personality:** obsessive personality are more liable.

Clinical picture of anxiety disorders:

A- Psychological symptoms:

- Unexplained fears apprehension, irritability.
- Insomnia, night mares.

B- Somatic manifestations:

CVS: Tachycardia. Lt mammary pain, systolic hypertension.



GIT: Nausea, Vomiting, indigestion, diarrhea, anorexia.

Chest: Sighing, tightness, hyperventilation resulting sometimes in tetany & numbness (Hyperventilation syndrome)

Urogenital: Frequency, dysmenorrhea, impotence, premature ejaculation.

Nervous System: Headache, tremors, hyperreflexia.

Muscles: Pains due to muscular spasm.

Skin: Rashes, urticaria, & neurodermatitis

C- Cognitive manifestations:

- Lack of concentration
- Lack of remembering & recall
- Decreased ability to learn

D- Psychosomatic illness:

- Bronchial asthma, CHD, ulcerative colitis, peptic ulcer.
- Psychosomatic illness usually occur with chronic generalized anxiety.

Classification of Anxiety Disorders:

1. Generalized Anxiety: (chronic persistent anxiety).

2. Panic Disorders (acute anxiety):

- Recurrent attacks of severe anxiety which are sudden & unpredictable
- They are not related to a particular situations
- They may lead to secondary agoraphobia i.e. fear of being in open spaces, outside the home a loner in a crowd.

Diagnostic C/P for panic disorder

(At Least 4 of the following features must be present during the attack)

- | | |
|-----------------------|-----------------|
| - Shortness of breath | - Paresthesias |
| - Tachycardia | - Chest pain |
| - Shaking | - Fear of dying |
| - Abdominal distress | |

3. Terror status: (acute anxiety):

Immobility characterizes this anxiety condition. Also there are tachycardia, sweating, palpation & trembling.

Investigations of anxiety disorders:

- 1- ***No specific test for anxiety.***
- 2- Non-specific EEG changes.
- 3- ***Echocardiogram*** show mitral valve prolapse in good percent of patients.
- 4- ***T3, T4, VMA, blood sugar, ECG:*** to exclude medical condition.

Treatment of anxiety:

1. Psychotherapy:

This to ventilate all his conflicts & through suggestion, reassurance & guidance getting him to overcome his anxiety, group psychotherapy may be used.

2. Environmental & social manipulations:

to remove the patient from the disturbing factors.

3. Slow breathing to reduce physical symptoms of anxiety:

- Breath in for 4 seconds & out for 4 sec. & pause for 4 sec before breathing in again.
- Practice 20 min morning or night (5-10 min is better than nothing)
- Use before & during situations that make you anxious.
- Regularly check & slow down breathing throughout the day.

4. Drugs:

A) Generalized anxiety

Benzodiazepines

- Diazepam 2-10 mg / 8 hr but should be reduced & tailed off after 3 weeks or dependence may occur.

Non benzodiazepines:

- Buspisone (Buspar) 5-10 mg bid.
- Antidepressants e.g. amitriptyline 10-100 mg at night.
- SSRIs
- Inderal 10-30 mg / day controls out manifestations.

B) Panic disorders

Tricyclic anti-depressant

e.g. clomipramine (Anafranil 25 mg tab) 100-150 mg/D

Selective serotonin reuptake inhibitors (SSRIs)

- Prozac 20 mg/D
- Cipram 20 mg/D
- Lustural 50 mg/D

Benzodiazepines

- Alprazolam (Xanax®) 0.25-0.5 mg/d

Non benzodiazepines buspar

Beta-blockers

Thyrotoxicosis and anxiety disorders

Thyrotoxicosis	Anxiety
- Warm sweating on the palm and dorsum of the hand - Hot hands - Sleeping pulse is high - Thyroid functions show increased T3 & T4 - Associated symptoms as ophthalmopathy	- Cold sweating on the palm only - Cold hands - Sleeping pulse is normal - Normal thyroid function test - Absent

Pheochromocytoma and anxiety

Pheochromocytoma	Anxiety
- No sense of apprehension - In attacks - ↑ VMA in urine - ↑ CA in blood	- Sense of apprehension - Usually present most of the time - -ve - -ve

Mitral valve prolapse and anxiety

Mitral valve prolapse	Anxiety
- Occurs in attacks - Choking - Chest pain - Click murmur on the heart - Echo +ve finding	- Occurs most of the time - Difficulty in breathing - Chest tightness - ve - -ve

Hypoglycemia and Anxiety disorder

Hypoglycemia	Anxiety
- excessive sweating - Improved by glucose intake - Decreased Blood Sugar level - History of DM, use of hypoglycemic drugs or insulin	- Sweating - Not improved by glucose intake - Normal Blood Sugar level - History of psychological troubles

Myocardial infarction and panic disorder

Myocardial infarction	Panic disorder
- Chest pain is compressing and may radiate to shoulder - Sense of impending death - Serum enzymes as CK, SGOT, and LDH are increased	- Left mammary stitching pain - Sense of impending death or becoming mad - Serum enzymes are normal

Posttraumatic stress disorders:

i.e. Anxiety produced by extraordinary major life stress. Or it is considered to be a reaction to severe stress.

Diagnostic Criteria of Post traumatic stress disorders:

- 1-The person has experienced an event that is outside the range of usual human experience e.g. seeing another person seriously killed or injured, sudden destruction of one's home.
- 2-The traumatic event is persistently re-experienced in the form of dreams or flash back episodes. Or distress at exposure to events that resemble the traumatic event.



3- Persistent avoidance of thoughts feeling associated with the trauma

Phobic Reaction

Definition:

A special form of fear which is characterized by:

- It is out of proportion to the demands of the situation.
- It can't be explained or reasoned.
- It is beyond voluntary control with avoidance (behavioral) of the feared situation.

Differential Diagnosis:

- **Normal fears** e.g. fear of snakes, dogs.
- **Phobic symptoms associated with** obsessive compulsive disorders (OCD), schizophrenia.

Types:

- **Agoraphobia** (Open spaces)
- **Claustrophobia** (Closed spaces)
- **Acrophobia** (heights)
- **Social phobias** (in which the affected person is exposed to the gaze of others or talk in front of people, it is common in childhood or adolescence).
- **Animal phobias** (zoophobic).
- **Illness phobias** (nosophobia) e.g. cancer.
- **Obsessive phobias** (see OCD).

TTT:

Psychotherapy: may be effective.

Behavior therapy: (it is the best treatment of phobias)

- **Systemic desensitization**: (gradual exposure to source of phobia)
The patient is exposed to feared object or situation in gradually increasing intensity with using relaxation techniques.
- **Implosive therapy**
The patient is exposed to the most intensively phobic situations for up to one hour.

Drug therapy

e.g. **Antianxiety drugs** before exposure to the feared situation.

TCA, SSRIs, BZD (see anxiety)

Obsessive Compulsive Disorders (OCD)

This is a neurotic illness ch.ch. by:

- Periodic or persistent subjective experience of a certain thought or action the patient realize that it is silly & illogic (absurd ideas)
- Continuous, **attempts to resist it**, (uncontrolled) so it is like compulsion الوسواس so there is **associated anxiety & depression**.



- This disease occurs commonly in compulsive personalities.
- Their prevalence 1-3% but many people do not request ttt.

Etiology:

- **Heredity**
- **Personality** (Compulsive personality = premorbid trait) associated with poor prognosis.
- **Physiological**: Dysregulation of serotonin neurotransmission
- **Organic brain disease**: e.g. postencephalitic

Clinical Picture:

A) Obsessions

1- Ideas, Images:

which are very silly & absurd comes to the patient's mind e.g:

- **Ideas**: which associates the name "god" with absurd words
- **Images**: sexual intercourse with his mother.

2- Impulses اندفاعات

are often of a suicidal or aggressive nature e.g.

- to push his friend
- to throw himself under a bus
- laugh in the mosque of church.

3- Phobias.

The phobias are related to impulses, the patient avoid things or situations which are the sources of his impulses e.g.:

- Phobias of kissing children if the impulses is to have sexual, relation with children.
- Phobia of going to mosques or even to pray if the impulses is to sing while praying.

4- Ruminations:

- The patient ask himself questions & does not reach to a conclusion e.g. where is god, why is my nose over my mouth.

B) Compulsions

The pt must follow a certain routines in his life as in. dressing, in washing, in writing e.g.

- he is compelled to wash his hands repeatedly after contact with certain things, checking or arranging.



These obsessional motor acts alleviate his anxiety.

Treatment:

Psychotherapy is necessary.

Behavior therapy.

Also repeated exposure to the contaminated objects followed by prevention of the response of the patient. Some patients are helped if they can observe a therapist behavior in presence of contamination.

Drugs:

- *Clopiramine* 50-150 mg/d (*Anafranil*) which is a tricyclic antidepressant
- One of the *SSRI group* (*selective serotonin reuptake inhibitors*) e.g.
prozac, cipram tab 20 mg tab (1-2 tab/D)
or Lustral, faverin 50 mg tab (1-2 tab/d)
- *also BB may be helpful*

هذا المريض يتبع أسلوب معين لا يستطيع تغييره و إذا حدث تغيير فإنه يشعر بالقلق؛ أيضا يشعر بالرغبة القهرية في غسيل الأيدي أو الاستحمام أو التأكد من غلق الباب أو الأ

Hysteria

(Conversion & Dissociation Reactions)

Definition:

It is a subconscious production of signs & symptoms to gain attention or to escape from a certain danger or threat (secondary gain), the symptoms usually have a symbolic meaning.

Hysteria comes from the Latin word Hysteron meaning the uterus, it was previously thought that the condition occurs only in females due to certain uterine movements, but it occurs both in females & males.

Dissociative conversion disorders has replaced this previously used term, but many clinicians still prefer to retain hysteria as a diagnostic category.

Etiology:

1. **Heredity Genetic factors:** may play a role especially in the personality disposition called hysterical personality. (see later).
2. **Emotional stress conflict** which may lead to conversion or dissociative reaction.
3. **Hysteria may occur in all social classes** but it is commoner in noneducated people of below average intelligence.

Clinical Picture:

II- Conversion reaction:

1- Motor Disturbances:

Paralysis:

- In the form of monoplegia, hemiplegia, or paraplegia.
- In comparison to organic hemiplegia proximal>distal, no clonus, no babinski, or specific distribution.

• Aphonia: the patient can not phonate words but continues to cough as the vocal cords are not affected.

• Tics, tremors, coma. stupor with no abnormal signs.

• Torticollis.

• Fits:

- No sequence of tonic then clonic movements.
- Occur in presence of audience.
- Never occur during sleep.
- No cyanosis, incontinence or tongue biting.
- There is resistance to interference.



NB: All motor symptoms have a symbolic meaning e.g. Aphonia as she cannot express her feeling, torticollis as she does not want to look at her husband who sleeps beside her.

2- Sensory disturbances:

- Anesthesia: frequently total with no specific distribution.
- Blindness: pupil reactive, patient Avoid object that would injure him
- Pain bizarre: related to emotional conflicts.

3- Visceral disturbance:

Vomiting, cough, hicough, pseudocyesis, globus hystericus.

II- Dissociative Reactions:

The personality is dissociated to escape from the suffering.

1. Amnesia:

(usually circumscribed or patchy) e.g. forgetting a shameful situations.

2. Fugues:

The patient may travel over long distance, the patient is unaware of his original life, he may forget everything that happened during the attack.

3. Sleep walking:

The patient Awakes from sleep, performs certain activities then return to sleep with amnesia about this period. Common in children due to stresses e.g. (School-parents)

4. Double or multiple personalities:

The patient acquires another personality through which he can behave in the way he likes then return back to his original personality with amnesia about the events that occurred. The acquired personality motivated by her subconscious desires.

5. Stupor & twilight:

State of clouding of consciousness during which patient may stop all physical & mental activities. It may be an escape from psychological trauma.

6. Ganser's syndrome (Hysterical pseudementia):

Occurs under severe stress as in prisoners; there is a childish, bizarre behavior; an educated patient may be unable to know the number of fingers.

Differential Diagnosis: Exclude organic brain disease

- Organic disorders of the brain
- Mental retardation.
- Functional psychosis.
- Neurological diseases.

Q: Dissociative amnesia: this include

- Amnesia

- *Fugues.*

- *Pseudodementia*

TTT: At first exclude organic causes

General rules:

- Solve his problem & regain normal adjustment.
- Try to keep patient At work.
- Marriage or divorce not recommended as a ttt.

Psychological ttt:

- **Suggestion** by ordinary psychotherapy
- **Supportive psychotherapy** to regain maturity in dealing with stressful situation.
- **Extracephalic electrical stimulation** for suggestion to induce movements in paralyzed muscles, voice in aphonia.
- **Drug treatment.** for associated symptoms only e.g. tranquilizers or antidepressants
- **Production of pain** e.g. ethyl chloride spray in the nose.

How can you differentiate between hysterical fits and epileptic fits?

Hysterical fits	Epileptic fits
- Occur in front of audience - Rarely hurt themselves - May be either tonic or clonic - Do not occur during sleep - Absence of incontinence, cyanosis, biting of the tongue - Attempts to pull their hair or tear their cloths	- Occur at any time - Usually injure themselves - Tonic then clonic - Can occur during sleep - Cyanosis, incontinence, and tongue biting occur - Absent

How can you differentiate between organic and hysterical hemiplegia?

Hysterical hemiplegia	Organic hemiplegia
- +ve sure sign of pyramidal - Proximal weakness is more - Flexor plantar response - No cranial nerve affection	- -ve - Distal weakness is more - Extensor plantar response - Cranial nerves are affected

How can you differentiate between hysterical coma and hypoglycemic coma?

Hysterical coma	Hypoglycemic coma
- In front of audience - No sweating - No convulsions - No effect of IV glucose - History of stress or psychological problem	- Anywhere - Sweating, tachycardia - Convulsions may occur - Good response to IV glucose - History of fasting or hypoglycemic overdose

How can you differentiate between Psychogenic amnesia and Amnesia due to organic condition?

Psychogenic amnesia	Amnesia due to organic condition
- Sudden loss of memory usually precipitated by emotional trauma - Most common type of loss is circumscribed amnesia in which the events of a short period of time are lost - Mild clouding of consciousness may	- Not related to stress - More common in elderly - Full return of memory rare and very gradual - Clear organic factor in history - Conscious attempt to fake loss of



occur in some cases

memory for secondary gain.

Somatoform Disorders

- *This group of disorders are characterized by repeated medical consultation for physical symptoms which have no adequate physical bases.*
- *In most cases a psychiatric assessment will show that the physical symptoms bear a close relationship with stressful life events or emotional conflicts.*

Presentations:

1-Somatisation disorder:

- More in females
- Usually chronic & fluctuating course over many years,
- Symptoms may be referred to any part of the body.
- Anxiety or depression may be present
- Unhelpful operations e.g. hysterectomy & cholecystectomy are common.

Examples:

- | | |
|-------------|---------------------------|
| - headache | - nausea |
| - dizziness | - sexual dysfunction |
| - vomiting | - menstrual irregularity. |

2-Hypochondrial disorders:

- It is a morbid preoccupation with the possibility of having a serious illness.
- Hypochondrial symptoms commonly occur in anxiety & depressive disorders but occasionally they are primary & persistent for many years.

Examples:

- Delusional parasitosis → consult dermatologist.
- Dysmorphobia → requests for cosmetic surgery.

3-Somatoform autonomic dysfunction:

- Symptoms are referred to organs which are under autonomic control.

Examples:

- Cardiac neurosis.
- Psychogenic hyperventilation
- Psychogenic vomiting.
- I.B.D.

4-Somatoform pain disorder :

- The common presentation is severe persistent pain, which can not be explained by a physical illness or physiological disturbance.

- Emotional conflicts or psychological problems are evident.

Differential diagnosis of somatoform disorders:

1. Organic disorders
2. Psychiatric illness
3. Factitious disorders
4. malingering
5. Conversion reaction

Management of somatoform disorders:

Organic disorders must be excluded.

- Most cases are chronic & complete recovery must not be expected
- Psychotherapy & anxiolytics.
- Antidepressant may be helpful.

Unexplained Somatic Symptoms

- Somatic symptoms not due to medical causes.

Differential diagnosis

1. Anxiety disorders.
2. Panic.
3. Depression.
4. Conversion disorder.
5. Somatoform:
 - Somatization.
 - Hypochondriasis.
 - Psychogenic pain disorder.
6. Neurasthenia.
7. Secondary to psychosis.
8. Factitious disorders.
9. Malingering.

Factitious Disorders	Malingering
- Voluntary inducing physical defect - Multiple hospitalization - Multiple operations - Severe acute symptoms, abdominal pain and bleeding tendencies - Abuse of analgesics and sedatives - Demanding examination	- No mental disorder - Voluntary production of false physical psychological symptoms - To avoid * Military * Severe distress at work - Resisting examination



Chronic Tiredness

Common Symptoms:

Compared with previous level of energy

- Tired all the time
- Tired despite rest
- Tired easily

this leads to

- disruption to work, social & family life
- affects ability to carry about routine & other tasks.
- Feelings of frustration.

Common triggers:

1. Psychological triggers:

- Depression
- Anxiety / stress
- Worry
- Doing too much
- Doing too little

2. Physical triggers:

Medical problems

- Anemia
- bronchitis
- asthma
- diabetes
- sleep apnea
- narcolepsy
- thyroid disorder
- influenza
- alcohol/drug use
- bacterial or viral infection
- chronic liver disease
- renal impairment
- Addison

Medications: → steroids, antihistaminics, Beta blockers

Treatment:

Supportive therapy (most often needed):

- Depression
- Worry
- Stress/life problems
- lifestyle change
- level of physical activity.

Medication for:

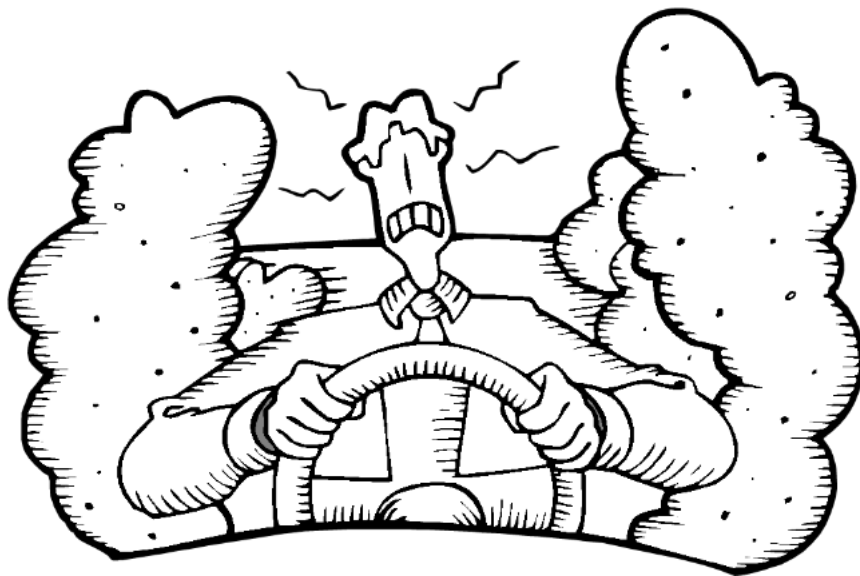
- other mental or physical disorders
- Certain anti-depressants are sometimes useful. (Tryptizole 10 mg, anafranil 25 mg)



- there are no effective medications specific to fatigue.

Behavioral strategies:

- Examine how well you are sleeping.
- Have a brief rest period about 2 weeks, in which there are no extensive activities.
- After periods of brief rest, gradually return to your usual activities.
- Plan pleasant / enjoyable activities into your week.
- Gradually build up a regular exercise routine.
- Do not push yourself too hard, remember build up activities gradually & steadily.
- Try to have regular meals during the day.
- Try to keep to a healthy diet.
- Use relaxation techniques, for example, slow breathing (see before).





Mood disorders

Classification of mood disorders:

1. *Manic depressive disorders:*
 - a. *Unipolar major depression (incidence about 3%)*
 - b. *Bipolar manic depressive disorders*
2. *Dysthymia, cyclothymia*
3. *Mood disorders secondary to*
 - *Medical condition*
 - *Other psychiatric disorders*
 - *Substance or drug induced*

Etiology:

1. *Heredity:* manic disorders run in families.
2. *Personality & constitution:* pyknic & cyclothymic (mood swings).
3. *Psychological factors:* psychological traumata, stress.
4. *Medical problems:* pre-menstrual, myxedema, cortisone therapy, cushing, encephalitis, pneumonia, infective hepatitis, pills, reserpine, electrolyte disturbances.
5. *Chemical:* decrease biogenic amine (norepinephrine, serotonin, dopamine) in depression, & increased in mania.

General Ch.Ch. of manic depressive disorders:

- Primary disturbance of mood this may vary between cheerfulness (*Mania*) & sadness (*depression*), the patient may have *unipolar cyclic depression* or *bipolar manic depressive* disorder.
- *Periodicity*, elevation or depression of mood alternate with free interval.

Clinical Features of manic depressive disorders:

I- The depression phase or depressive episode (major depression)

(*Female: male is 2:1*)

A- Mood changes

Ch.Ch. by diurnal variations (see table), there is hopelessness, no aim, no desire to live (Suicidal tendency), bad look to future.

B- Psychological changes:

1. Thought changes: Slow thinking, lack of concentration, self depreciation, *psychotic symptoms of depression* e.g. Delusions e.g. nihilistic (sense of death of systems or organs),



delusions of poverty, guilt feeling or delusion of guilt.

2. Hallucinations: rare (psychotic manifestation).

C- Behavior changes:

Slow movements, sad faces, neglect personal hygiene, social withdrawal, suicidal attempts, psychomotor manifestation e.g. retardation, stupor, agitation over activity.

D- Psychological changes:

Insomnia, anorexia, constipation, loss of sexual desire.

N.B.: Cognitive changes

- Negative view of the self (self depreciation)
- Negative view of the future (hopelessness)

II- Phase of hypomania & mania

hypomania is less & milder in quality than mania

- • Hyperactivity which may rarely lead to real achievement
- • Joyful activity, talkative, dressing in bright colors, flights of ideas
- • The mood is elated, delusion of grandiosity, power.
- • Insomnia, strong sexual urge & polyphagia.

N.B.: Involutional Melancholy:

This is the same as major depression but occurs at a later age, there are some differentiating points in this table.

	Manic-Depressive psychosis	Involutional Melancholy
Age	Any age, common in middle	Later life (menopause)
Sex	Female: Male = 3:2	More in females
Heredity	Genetically determined	Environmentally determined
Onset	Sudden	Insidious
Physique	Pyknic	Asthenic
Personality	Cyclothymic	Obsessional
Symptoms	Depression	Depression & anxiety More agitation More delusions
ttt	Less favorable response to ECT	More favorable response to ECT

Differential diagnosis:

- 1- Organic psychosis
- 2- Schizophrenia.
- 3- Other diseases e.g. alcoholism, myxedema, cushing d.
- 4- Personality disorders.

N.B.: depression may mask itself as another illness, i.e. it may be caused by another illness or may be concomitant with another illness or it may be a result of

treatment of another illness.

Medical Causes of Depression:

- **Pharmacologic.** steroids, methyl dopa, cimetidine, reserpine, cyclosporine, amphetamine withdrawal.
- **Infectious dis.** Influenza, viral hepatitis, IMN, T.B.
- **Endocrinal.** Hypothyroidism, cushing, Addison's, postpartum, hyperpara, menses related, D.M.
- **Collagen.** SLE, rheumatoid.
- **Neurological.** parkinsonism, stroke, multiple sclerosis.
- **Nutritional.** Vit B12, Vit C, Folate, Niacin deficiency, hypercalcemia
- **Neoplastic.** Cancer head pancreas, disseminated malignancy

Diagnostic criteria for major depressive episode:

- depressed mood.
- agitation or retardation
- guilt feelings
- diminished ability to think or to concentrate
- significant weight loss
- fatigue
- thoughts of death
- diminished interest or pleasure.

(at least 5 of the above symptoms must be present for at least 2 weeks)

Diagnostic criteria for manic episode:

a- Elevated or irritable mood

b- During the period of mood disturbance 3 of the following must to present:

- self grandiosity.
- Talkative
- decrease the need for sleep
- flight of ideas

c- Marked impairment in occupational functioning or in usual social activities

(Manic syndrome=a+b+c) (Hypomanic syndrome=a+b only.)

Treatment:

1. Hospitalization

With severe suicidal thoughts, rich delusions, guilt feeling, refusal of food, or severe agitation or retardation.

2. Supportive psychotherapy for explanation & reassurance .

3. Drug therapy:

A-For depression:

Antidepressant, they increase the level of the 5HT, NA, DA in the brain

i. Tricyclic antidepressants:

(prevent reuptake of neurotransmitters e.g. NA, 5HT, DA)

a- **Stimulants** e.g. *tofranil* 75-200 mg/d given in retarded depression with less psychomotor activity.

b- **Sedative** e.g. *tryptizol* 75-200 mg/d , *Anafranil* 75-200 mg/d indicated in agitated, anxious depression.

ii. Tetracyclic antidepressants:

e.g. *Ludiomil* 75-150 mg/d, *Monocyclic* (Vivalan 150-300 mg/d), both given to elderly as their anticholinergic effects is minimal.

iii. MAOI: parstelin 3-6 tab/d

iv. Recent antidepressant (SSRIs).

Fluoxetine (prozac) with no anticholinergic effects.

NB: all antidepressants will start their maximum effect in 2-3 weeks & maintenance should continue for 6-8 months to guard against relapse.

B-For Mania:

i- Phenothiazines:

eg: *chlopiramine* 100-800 mg/d, *Sparine* 300-800 mg/d for hyperactivity & insomnia.

ii- Butyrophenons: e.g. Haloperidol (safinace) 5 mg tab 10-20 mg/d.

iii- Lithium:

- as a prophylactic agent in recurrent mania or bipolar manic - depressive.
- Lithium carbonate (priadel) 400 mg tab 2 tab/D with regular measurement of serum level as it is nephrotoxic & may alter thyroid function
- We can use Lithium during the attack of mania with the other medications

iv. Carbamazepine (tegtrol):

400 – 1200 mg/d Recently used as an alternative prophylaxis for pt who do not respond to lithium.

v. Na valproate (Depakine) can be used also as mood stabilizers.

4. ECT:

- Suicidal thoughts or attempts
- Good for involutional melancholy.
- Indicated in severely retarded, agitated pts & do not wait for drugs to act within 3 weeks.
- Acute manic episode.
- Those patient usually need 6-8 times spaced twice or thrice weekly.

Other mood disorders

1) Dysthymia

- It is a chronic depression not fulfilling criteria for major depression
- Depressed mood and irritability
- Sleep and appetite are increase or decreased
- Decreased concentration and fatigue
- TTT: - Antidepressant
- Antianxiety
- Psychotherapy

2) Cyclothymia

- Mood swings with persistent mood instability
- There are periods of hypomania and depression
- TTT: - Mood stabilizers
- Psychotherapy

3) Mood disorders due to medical diseases

- Depression (See before)
- Mania: - Brain tumors
- Endocrinal (hyperthyroidism)

4) Substance induced mood disorders:

- Depression: sedatives, CCP, steroid & methyl dopa, Inderal, benzodiazepines
- Mania: steroid - amphetamines – hallucinogens

5) Mood disorders 2ry to another psychiatric disease

- Anxiety
- Alcoholism
- Schizophrenia
- Drug dependence

(Old classification of depression)

	Reactive Depression	Endogenous depression (Major)
Cause	Direct cause found	No immediate cause
Personality	Emotionally labile	Cyclothymic
Heredity	Weak	strong
Environmental	Strong	above 30
Age	Any age	+++
Clinically		
<i>Retardation</i>	May be +++	+++
<i>Agitation</i>	--	+++
<i>Guilt feeling</i>	--	+++
<i>Delusions</i>	Absent	++
<i>Diurnal rhythm</i>	worse in the evening	worse in the morning
<i>Sleep</i>	disturbed early in sleep	sleep with early morning awaking
<i>Suicide</i>	Rare	common
<i>Social withdrawal</i>	uncommon	common
<i>Somatic symptom</i>	Mild	hypochondriasis
<i>Contact reality</i> with	Present	absent
Prognosis	Recovery	periodic
Ttt	psychotherapy, sedative, antidepressants	psychotherapy, antidepressant, ECT



Schizophrenia

This is the severest form of functional mental illness, complete recovery may occurs either spontaneously or with ttt.

Definition:

Psychiatric disease ch.ch. by disturbances of thinking, emotion, volition, perception & behavior with withdrawal from reality.

Prevalance: 1% of population

Age: more between 15-30 yrs

Sex: Almost equal

Etiology:

1. Heredity : it is more in relatives of pts, if both parents affected the incidence in the offspring will be about 35%, if one parent is affected the incidence is 8%.
2. Personality: may occur in any personality but schizoid personality gives the poorest prognosis
3. Biochemical: disturbance in the central C.A. synapses mainly as over activity of dopamine receptors which should explain the psychotic action of dopamine agonist drugs & the anti-schizophrenic action of phenothiazines
4. Cerebral specific EEG changes, but P.M CT & MRI studies revealed gliosis in brainstem, cortical atrophy, ventricular dilatation
- 5 slow virus infection may be present.
6. Predisposing stresses e.g. physical illness, steroids , operations, drug abuse, puerperium, may trigger the illness.

Symptomatology:

1- Disorder of thought (thinking) اضطرابات التفكير

• Formal thought disorder. اضطرابات شكل التفكير

- There is loss of association (Incoherence)
- Incomprehensible speech
- Lack of abstraction ((لا يعرف معنى الأمثال الشعبية

• Disturbance of thought control:

- Thought reading الآخرين يقرؤون أفكاره
- Thought withdrawal أفكاره تسحب منه
- Thought insertion زرع الأفكار فى رأسه
- Thought broadcasting إذاعة الأفكار

• Disturbance of stream اضطرابات مجرى التفكير

- Thought retardation بطء التفكير



- Thought block توقف تفكير المريض فجأة و الحديث عند سماعه
- Disturbance of content اضطرابات محتوى التفكير

Delusions: False fixed beliefs not related to the educational & social background of the patient, also cannot be corrected by reassurance

- Grandiose delusion العظمة
- Delusions of infidelity or jealousy الغيرة
- Delusions of reference التلميح أن الحديث بين اثنين يدور حوله
- Persecutory delusions الاضطهاد
- Religious

2- Disorder of emotion:

- Flat emotions
- Inappropriate emotion
- Depressive or euphoric emotion
- Prostitution, addiction, with indifference.

3- Disorder of volition: اضطراب الإرادة

- There is loss of will power, lassitude with hesitation & inability to make decision.
- Marked loss of self-care & hygiene. Lack of drive

4-Disorder of behavior: اضطراب السلوك

- Withdrawal, neglect of personal hygiene & sometimes suicidal behavior. violence or excitement may occur.
- Catatonic symptoms e.g. maintained posturing for long time, catatonic excitement or stupor

5-Disorder of perception: اضطراب الإدراك

Hallucination i.e. sensory perception without stimulus

- Tactile
- Visual rare
- Olfactory
- Auditory(common)

Illusions i.e. misinterpretation of a real stimulus

Auditory Hallucination in the form of voices discussing the pt in the third person, also voices keeping up a running commentary on the pt thoughts or actions. Also it may occur in the form of threatening

6-Catatonic manifestations

- Abnormality of movement, ranges from over-activity or excitement to marked immobilization & retardation.
- Also autonomic obedience – maintain posturing, waxy flexibility.

7-Mood disorders

8-Negative symptoms:

- Apathy, social withdrawal
- blunting of affect
- poverty of thought

Types Of Schizophrenia:

1-Simple Schizophrenias

- This can be missed for many years, the onset is slow symptoms mainly emotional, lack of volition, withdrawal & failure at work or study. They are emotionally flat but there are no delusions or hallucinations, they may end in addiction, crime & prostitution. (So it is mainly disturbance of volition & emotion)

2-Hebephrenic schizophrenia: (disorganized)

- Occurs at any early age, all types of disorders are present. Delusions & hallucinations may occur.

3-Catatonic schizophrenia:

- ***Excited catatonia:*** Motor activity with aggression, excitement & he may destroy everything around him.
- ***Inhibited type:*** e.g. immobility, stupor, negativism.

4-Paranoid schizophrenia:

- Mainly hallucinations & delusions e.g. (persecutory, jealousy). It does not lead to marked personality deteriorations. older age

5-Undifferentiated:

- when the symptoms don't belong to any other type or mixed criteria are present.

6-Residual schizophrenia: (mainly -ve symptoms)

- Chronic residual cases with traces of thought & emotional disorders

7-Schizo-affective:

- A mixture of schizophrenia with depressive or manic symptoms.
- It is considered to be an affective disorder with psychotic manifestation

- ***The acute phase*** of schizophrenia usually presented by ***positive symptoms*** e.g. Delusions, hallucinations, disorder of thinking & speech
- ***The chronic phase*** usually presented by ***negative symptoms***

Differential Diagnosis of Schizophrenia:

1- Organic psychosis

- a) Brain disease e.g. frontal lobe tumors , epilepsy, encephalitis.
- b) systemic diseases affecting brain e.g. hepatic encephalopathy, cushing

disorder.

2- Chemical toxicity e.g. LSD, hashish → hallucination.

3- Drugs → cytotoxic drugs, steroid.

4- Affective psychosis (mood disorders), but they are ch.ch by periodicity

5- Psychopathic states this is a long standing personality disorder.

6- Post partum psychosis

Diagnostic criteria:

- a- Presence of characteristic psychotic symptoms e.g. delusions, hallucinations.
- b- Functioning in work, social relations self care markedly decreased.
- c- Mood disorders must be ruled out.
- d- Duration of illness at least 6 months.
- e- No organic factor initiated.

Prognostic Factors in schizophrenia

Good Prognostic factors:

Acute onset
obvious ppt factor
Affective symptoms
-ve F.H.
Normal premorbid personality
Catatonic symptoms

Poor prognosis

Insidious onset
No ppt factor
No affective symptoms
+ve F.H.
Schizoid personality
No catatonic symptoms.

Prognosis:

- 15% full recovery with no relapse
- 50% recovery completely with repeated relapses
- 25% persistent positive & negative symptoms.
- 10% die by suicide

Treatment:

1-Hospitalization

2-Genetic counselling.

3-Social & occupational therapy

may be of value. Also family therapy & education is important.

4-Drugs & Electroconvulsive therapy.

- **ECT** See later, used in catatonic, schizo affective & excitement
- **Phenothiazines** {Chloropromazine 100-200 mg/d) TDs

- **Haloperidol**/10-30 mg/d (antidopaminergic)
- **Antiparkinsonian** drugs e.g. *cogentin* (2 mg 1x2) (*benztropine*) to avoid extrapyramidal manifestations.
- **After S&S controlled** (usually after 4 •weeks dosage can be reduced as maintenance dose).
- After 6 m in remission, drug can be withdrawn for trial period to see if relapse occurs.
- If relapses occur therapy is repeated again.
- Some patients may be on lifelong maintenance therapy to prevent relapse.

1. Long acting drugs e.g. moderate 25 mg amp every 2 weeks IM in case of poor compliance in chronic cases
2. New antipsychotic
 - *clozapine* (*leponex*)
 - *Risperidals*



Sexual Disorders

Adolescence:

Sexual problems are universal at this time. The adolescent, though sexually mature is psychologically immature & unable to take on adult responsibilities, the resulting conflict leads to anxiety & a search for sexual outlet.

Homosexual Behavior:

The sexual activities between members of the same sex is common in adolescents, especially in closed community as (school). It usually represents a transitory phase & disappear after maturity. Guilt feelings is common.

Impotence & frigidity:

In the adult, there are great individual variations in libido & sexual performance. Consequently, some cases of impotence & frigidity can be

considered as being one extreme of the range of the normal. Other cases are due to physical or mental illness & others to emotional immaturity e.g. fear of sexuality.

Difficulties of this kind are commonest at the beginning of marriage (Honey moon impotence). Anxiety from any cause is a frequent cause of impotence & premature ejaculation it is a common presenting symptom in anxiety neurosis. Frigidity is common in hysteria.

Sexual Anomalies:

Homosexuality:

Genetic factors be of etiological importance in some cases but there are no endocrine abnormalities. Contrary to popular belief the homosexual is rarely abnormal appearance or manner. In many cases psychogenic factors predominate e.g. disturbed parent - child relationship

Exhibition:

This is exposing oneself to obtain sexual pleasure. It usually occurs in males & consists of the exposure of the genitalia.

Transvestism:

Dressing in clothes of the opposite sex.

Fetishism:

for the normal sexual object another is substituted which is related to it but is totally unfit for the normal sexual aim.

Sadism

This is obtaining pleasure from acts of cruelty.

Masochism:

This is the seeking of sexual pleasure from what would normally be painful.

Treatment:

-*Psychotherapy* in suitable cases

-*Behavior therapy*

Organic Psychiatric Disorders

- *Organic mental illness are caused by anatomical or physiological disturbances occurring primarily in the brain or central nervous system or from physical illness elsewhere in the body, organic pathology should be suspected where psychiatric symptoms in the presence of the following:*
 1. Clouding of consciousness.
 2. Sudden deterioration of intellectual powers e.g. memory, orientation.
 3. No positive emotional factors in aetiology.
 4. History of trauma neurological signs.



- This group of disorders results from pathological lesions within the brain.
- They can be classified as acute or chronic.

1-Acute (Delirium):

It is also known as **acute confusional state**, involves a transient global impairment of mental function of acute onset. ***It is ch.ch. by:***

1. Impairment of consciousness:

The patient appears drowsy & lethargic, there is also impaired attention & concentration.

2. Memory disturbances:

All aspects of memory are affected. One of the early manifestations is disorientation in time & place.

3. Perceptual disturbances: macropsia, micropsia, & hallucinations.

4. Difficulty in thinking.

5. Emotional changes: e.g. anxiety, irritability, & depression.

6. Psychomotor changes:

Agitation - restlessness, hyperactivity to a dangerous degree.

Causes of acute confusional state:

Intracranial:

- Trauma
- Vascular e.g. TIA, hge & infarction.
- Epilepsy,
- Infection e.g. encephalitis & meningitis.
- Tumor

Extra cranial

- Infections e.g. pneumonia & septicemia
- Toxic e.g. alcohol & anticholinergics.
- Endocrine e.g. hyper or hypothyroid, Cushing \$.
- Metabolic e.g. uremia. LCF
- Hypoxia
- Vitamin deficiency e.g beriberi, pellagra & B12 deficiency.

Treatment:

- 1.The underlying cause must be determined.
2. The specific ttt of the cause.
3. *Chlorpromazine* or *Haloperidole* are of choice except in delirium tremens when *BZD* are preferred.

II-Chronic (Dementia):

- ***Dementia is defined*** as a clinical syndrome ch.ch. by loss of intellectual function in the absence of impairment of consciousness.

- ***Dementia is predominantly associated with the elderly, but in some disorders e.g. Alzheimer's diseases & Huntington's chorea, the onset of symptoms occurs in middle life these conditions, known as presenile dementia with strong family history.)***

Features of dementia are:

- ***Loss of general intelligence.***
- ***Memory impairment.*** events of the recent can not be recalled.
- ***Personality changes.*** there is decline in personal manners & social awareness.
- ***Emotional changes.*** depression, anxiety or irritability may dominate the clinical picture.

Etiology of dementia:

11. Degenerative:

- Alzheimer's
- Huntington's chorea
- Parkinsonism

2. Vascular:

- Cerebrovascular diseases.
- Cerebral emboli.

3. Trauma:

- Post traumatic dementia e.g. boxers.
- Encephalopathy.

4. Space occupying lesion:

5. Infections:

- Encephalitis.

6. Endocrinal:

- Hypothyroidism.
- Hypoglycemia.

7. Metabolic liver & renal failure.

8. Hypoxia.

9. Vitamin deficiency as B12 & folate

NB. Alzheimer's Disease:

- It is a primary cerebral disorder.
- It is insidious in onset, often in the middle life, but the incidence is higher in later life.

Pathology:

- Widespread cerebral atrophy
- Microscopy shows reduction of neurons with amyloid & aluminum silicate deposition.
- Also there is wide spread disturbance at cortical & subcortical cholinergic neurotransmission.

NB. Cerebrovascular Dementia:

- This usually follows a series of acute strokes or a single major stroke, there, are focal neurological signs.
- A more gradual onset occurs following a series of ischemia episodes which produce multi-infarct dementia.

Investigations for dementia,:

- Full blood count
- Liver functions
- Thyroid functions
- HIV Ab
- Kidney functions & electrolytes
- CT brain scan

Treatment:

- Any reversible cause should be treated.
- Hospitalization.
- Small dose of phenothiazines for excitement as they are very sensitive to sedatives.
- Cholinergic enhancement can improve memory in cholinergic deficit as in Alzheimer's disease (Tacrine 40-160 mg/D) = tetrahydroaminoacridine.



Drug Dependence & Substance Use disorders

Definition:

Addiction has been defined as a state of periodic or chronic intoxication produced by the repeated consumption of the drug, with physical and/or psychological dependence.

Its Characteristics include:

- An overpowering desire or urge to continue taking the drug & to obtain it by any means.
- Tendency to increase the dose (tolerance) to reach the same effect
- Presence of withdrawal symptoms in case of abstinence

Main presentations

- Mood changes
- Accidents
- Sleep disorders
- Infections (contaminated needle)

Social factors in Addiction:

It's true that addiction requires a vulnerable personality. The reasons for commencing drugs found to be in this order.

1. Persistent pain e.g. renal colic
2. Pressure of work.
3. Marital difficulties.
4. Psychiatric illness.

TTT of Addiction:

1. Admission to hospital is essential to give

- Analgesics for pain
- Antiepileptics for seizures
- Sedatives, antipsychotics for excitements
- Good nutrition

2. Abrupt withdrawal modified by the use of *Lorgatcil (phenothiazines)*, withdrawal from alcohol may require benzodiazepines.

3. After withdrawal supportive psychotherapy & adequate follow up are needed

4. Aversion treatment

For example

a- Apomorphine can be given with alcohol to produce nausea & vomiting. Gradually he will develop a condition reflex associating alcohol consumption with unpleasant symptoms.

b- Antabuse 0.5 gm daily: this substance interferes with normal oxidation of alcohol & produces a form of acetaldehyde poisoning. So the patient experiences flushing, tachycardia, headache, nausea & vomiting.

5. Treatment of drug toxicity

6. Occupational therapy and religious group.

I. CNS Depressants

Alcohol Dependence

Clinical feature of abuse

Chronic use

- Mood symptoms
- Peripheral neuropath
- Korsakoff's syndrome
- Wernick's encephalopathy
- Medical complications(see later)
- Delusional disorders
- Black out

Toxicity

- Incoordination
- Slurred speech
- Nystagmus
- Delirium, coma

Withdrawal

- Sweating
- Seizures
- Tremors
- Delirium tremors

Management:

- 1- Advice about the harmful effects of alcohol
- 2- Supportive psychotherapy
- 3- *BDZ* of choice for alcohol withdrawal *Diazepam* 20mg 4 times/d
- 4- Vitamins
- 5- *Phenothiazines* for hallucination
- 6- *Disulfiram* → alcohol intolerance
- 7- Aversion ttt as before (*Apomorphine*)

Harmful effects of alcohol abuse (systemic complications)

Heart

- Cardiomyopathy.
- Hypertension.

Liver:

- Fatty hepatitis
- Cirrhosis
- Cancer

Muscles & skeletal:

- Myopathy
- Gout

Endocrine:

GIT:

- Oes. cancer
- Gastritis
- Pancreatitis
- Mallory Weiss syndrome

Neuro

- Neuropathy
- Cerebellar degeneration

Chest

- Pneumonia
- TB



- Hypoglycemia
- Infertility.

Skin

- Spider n.
- Palmar erythema.

Opiates

- *Morphine, heroin, codeine are the main drugs in this group*
- *Physical dependence occurs within few wks.*
- *IV users liable to HBV& HIV& infective endocarditis in tricuspid valve.*

Chronic use

- Mood changes
- Legal problems
- Apathy
- Behavioral disturbance

Toxicity

- Constricted pupils
- Colic
- ↓ temperature
- respiratory depression

Withdrawal symptoms

- Rhinorrhea
- Lacrimation
- Tachycardia
- Facial flushing
- Vomiting
- Diarrhea
- Hypertension
- Yawning

Treatment

- 1- Hospitalization
- 2- Gradual withdrawal.
- 3- Drugs to decrease the withdrawal symptoms (*phenothiazines*)

Barbiturates

Chronic use → cognitive impairment, behavioral disturbance and dysphoria

Toxicity

Ataxia, Nystagmus, RC depression, coma

Withdrawal Symptoms of Barbiturates

- Insomnia
- Restlessness
- Convulsions
- Body aches
- Anxiety
- Tremors
- Delirium

Management

- Hospitalization
- Forced alkaline diuresis
- Doxopram + oxygen inhalation + ventilator
- Gastric lavage

Benodiazepines:

- Tolerance occurs after 6 wks of daily intake
- Withdrawal symptoms occur if the drug stopped abruptly
- features of chronic use and toxicity similar to barbiturates.

Withdrawal symptoms:

- Anxiety
- Epileptic fits
- Insomnia
- Hallucination
- Paranoid delusions, delirium

TTT:

- Reduce daily dose gradually
- Provide regular counseling
- Avoid other drugs e.g.: BB & antidepressants

II. CNS stimulants

Ephedrine

- Chronic use → Anxiety
- Toxicity → sympathetic over activity
- Withdrawal → fatigue and depression

Amphetamines & Cocaine

- Stimulate CNS; elevate the mood
- Decrease the appetite
- Withdrawal → depression, fatigue
- Chronic Ingestion → paranoid schizophrenia like (psychosis)

III. CNS Halucinogens

LSD:

- Chronic ingestion → psychotic illness, hallucination, euphoria.
- Toxicity → Red eye, arrhythmia, hypoglycemia, Impaired coordination
- Withdrawal → irritability and mood changes

Cannabis

- Derived from plant.
- Usually smoked mixed with tobacco
- It quickly produce sense of relaxation & well being.
- Psychological dependence is common but tolerance & withdrawal symptoms are unusual.
- Toxic confusional state occurs after heavy consumption.
- Long term consequences of regular consumption (motivational syndrome = apathy & slothfulness)
- Long term use also lead to cerebral atrophy

Bhang

- The active principle in it is 9 delta tetra hydrocannabinoid
- Presentation of impaired distance & time perception, in huge doses it may lead to hallucinations.
- It can also be associated with panic attacks especially in the naive abuser (first time)
- It can also induce paranoid reaction
- It is mainly associated with psychological dependence.
- It is one of the main gateway drugs that can lead to further indulgence in abuse of other substances (i.e. lead to addiction of other substances e.g. heroin. cocaine)

•TTT

- Mainly in the form of psychotherapy (individual as well as group therapy)
- Family therapy

Pts with dual diagnosis (i.e. abusing Bhang + having other psychiatric disorders)
Should receive ttt for both

Sleep Disorders

1- Insomnia

- a- Difficulty falling asleep
- b- Frequent awakening.
- c- Early morning awakening.

2. Excessive sleepiness

- a- Excessive day time sleepiness
- b- Sleeping too much

Either this or this will lead to :

- Difficulties at work, social & family life.
- Makes it difficult to carry out routine or desired tasks.

Common Causes:

1. Physical causes:

Medical Problems:

- H.F.
- Pulmonary disease
- DM
- Sleep apnea
- Pains
- Hyperthyrodism, hypothyrodism.

Medications:

Steroids, decongestants, NSAID

2. Psychological causes

- Depression.
- Anxiety / stress

3. Lifestyle Causes :

- Noise
- Too hot Or too cold.
- Tea, coffee & alcohol.
- Heavy meal before bed
- Mental or physical activity.
- Daytime naps
- Irregular sleep schedule

What treatment can Help:

Supportive therapy is the preferred ttt

Supportive therapy for:

- Stress/life problems.
- Anxiety
- Depression.
- Changes to life style & sleep habits

Medication for insomnia

1. *with depression*, give sedative antidepressant e.g. amitriptyline.



2. ***with anxiety***, short acting benzodiazepines not taken for longer than 3 wks.

Lifestyle Change Strategies and sleep hygiene:

- *Try to minimize noise in your sleep environment, if necessary consider ear plugs.*
- *Try to make sure you are not too hot or too cold.*
- *Reduce the amount of alcohol, coffee & tea that you drink, especially in the evenings.*
- *Try to avoid eating or drinking before going to sleep*
- *Try to have your dinner earlier in the evening rather than later.*
- *Don't lie in bed trying to sleep. Get up & do something*
- *Have regular times for going to bed at night & waking up in the morning.*
- *Reduce mental & physical activity during the evenings.*
- *Increase level of physical activity during the day, build up a regular exercise routine.*
- *Avoid day time naps during the day, even if you have not slept the night before.*
- *Use relaxation techniques, for example, slow breathing.*

3. Parasomnias

Sleep walking:

during sleep walking vision and coordination remain intact but serious accidents can occur. These patients sleep in a protected environment so, it is impossible for them to fall from windows or downstairs.

Night terrors:

Start with a frightening scream which is associated with sweating, increased heart and respiratory rate. The patient is usually unable to recall episodes (unlike nightmares).

Parasomnias resolve with improved sleep hygiene especially reduced consumption of alcohol and caffeine.

Child Psychiatry

There are two factors which have contributed to the recent recognition & expansion of child psychiatry :

1. *The origin of neurotic & psychotic illness of adult life is found in the experiences of early childhood according to the psycho-analytical school.*
2. *Psychiatric treatment of children may prevent psychiatric illness of adult life.*

There are many factors which may influence the development of psychiatric illness:

- a- Disharmony bet. the parents.
- b- Maternal over protection.
- c- Excessive b strain or competition with an elder brother.
- d- Divorced parents.

Classification:

a- Behavior Disturbances:

- 1- ***Sleep***. insomnia, sleep walking, night mares, night terrors.
- 2- ***Food***. refusal of food, nausea, vomiting
- 3- ***Excretory Functions***. Nocturnal enuresis
- 4- ***Psychomotor***. Hyperkinesia.
- 5- ***Conduct disorders***

b- Psychoneurotic Disorders:

- 1- Depressive reaction
- 2- Anxiety.
- 3- Irritability.
- 4- Hysteria.

c- Psychotic Disorders:

- 1- Schizophrenic syndrome
- 2- Affective psychosis (Mood disorders)

Treatment:

Psychotherapy to the child & the parents.

Drugs e.g. tranquilizers.

Child psychiatric and mental disorders

I. Mental retardation (MR)

Types:

1. **Mild MR** (IQ 50-70%) = moron
2. **Moderate MR** (IQ 30-50%) = imbecile
3. **Severe MR** (IQ < 30%) = idiots

Management

- | | |
|-------------------|---------------------|
| - Special schools | - Speech therapy |
| - Rehabilitation | - Family counseling |

II. Attention – Deficit/hyperactivity disorders

Attention deficit symptoms

- Often fails to give close attention to details or makes careless mistakes in school work
- Often does not seem to listen when spoken to directly
- Is often easily distracted by stimuli
- Often does not follow through on instruction and fails to finish school work

Hyperactivity

- Often leaves seat in classroom
- Often talks excessively during inappropriate situations

Impulsivity

- Often blurts out answers before questions have been completed
- Often has difficulty in a waiting turn

Types

1. Attention – deficit/Hyperactivity disorder **combined type**
2. Attention deficit/Hyperactivity disorder predominantly **inattentive type**
3. Attention – deficit/hyperactivity disorder predominantly **hyperactive impulsive type**

Management:

1. Methylphenidate, side effects e.g. growth retardation
2. Tofranil
3. behavioral therapy

III. Conduct disorder

This is a pattern of behavior in which the basic rights of others or rules are violated

1. Aggression to people or animals
2. Destructional property
3. Violation of rules

Management:

- Reward the positive behavior
- Anti-aggressive medication as Tegretol

IV. PICA

Persistent eating of non nutritive substance

For example: eat paint, plaster or cloth usually no specific biological abnormalities

V. Stuttering

Disturbance in normal fluency and time patterning of speech that interferes with academic or occupational achievement or with social communication.

Stuttering may be characterized by one or more of the following:

- Sound and syllable repetitions

- Sound prolongation
- Broken words e.g (pauses within a word)

Management:

- Speech therapy
- Drugs as haloperidol
- Support for parents

VI. Enuresis

The child with enuresis continues to urinate at inappropriate times & places after the time when he should have been toilet trained 2-4 yrs, male > female

a- Primary: no period of bladder control

- 1- Nocturnal enuresis
- 2- Diurnal enuresis.

B- Secondary

(Develops after a period of at least 1 yr of good bladder control)

Etiology

- 1- DM, DI
- 2- Spina bifida
- 3- UTI, bladder anomalies
- 4- Psychological factors

Treatment

Non pharmacological

- Decrease fluid after dinner
- Awakening the child to urinate after 1-2 hrs of sleep
- Bladder exercise (to increase function capacity of the bladder)

Medications

- TC antidepressants e.g. imipramine 10-25 mg at night
- Desmopressine nasal spray

Psychotherapy

VII Encopresis

Repeated passage of feces into inappropriate places whether involuntary or intentional.

Drugs causing Psychiatric Manifestations

- Anticonvulsant (phenytoin) → confusion, Hallucinations
- NSAID → Anxiety, insomnia
- Steroid pills → depression



- Sympathomimetics → insomnia
- Anticholinergic → restlessness delirium
- Tetracycline → depression

Hormones

- Thyroxin → Anxiety
- Androgen → euphoria
- Estrogen → well being
- Insulin → Anxiety

Antihypertensives

- Aldomet → depression
- Inderal → nightmares

Psychiatric Presentation Of Medical diseases

Endocrinal

- Hyperthyroidism → anxiety
- Hypothyroidism → depression
- Hyperparathyroidism → depression
- Addison → depression
- Pheochromocytoma, Hypoglycemia → anxiety
- Inf viral → depression
- Wilson → psychosis
- SLE → depression

Psychosomatic Disorders

Mechanism

Activation of autonomic NS & neuro endocrine system e.g. Thyroxin, cortisol

CVS: CHrD, Hypertension, arrhythmia

Respiratory: asthma, Hyperventilation

GIT: peptic ulcer, IBD, anorexia

Musculo-skeletal: Rheumatoid Arthritis

Endocrinal: DM – Hypertension, exacerbated by stress

NB: Type A personalities have cholesterol, ↑ LDL & triglycerides → Myocardial infarction

Psychiatric Emergencies

Definition: It is a disturbance of: behavior, emotions, thinking &/or action for which

emergency & immediate intervention is required.

Epidemiology: 10% of emergency pts are due to psychiatric disorders.

1- Excitement & Violence:

Excitement is: The increased motor activity & extensive psychiatric activity, often accompanied by autonomic hyperactivity.

Violence is: forms of behavior that can endanger life or harm others.

A- Excitement or violence with a psychiatric disorder.

1- Psychotic disorders: (Acute psychosis).

2- Mood disorders:

- *Manic episode*: expansive or irritable mood)
- *Depressive episode*: present with suicidal attempts

3- Personality disorders:

Explosive personality disorder, borderline personality disorder, antisocial personality disorder, & hysterical personality disorder.

4- Dissociative disorders: patients may present with hysterical excitement

B- Excitement with Medical disorders:

The following include medical disorder may present with violent behavior or excitement

1- Major organ dysfunction: Liver, kidney, heart, lung.

2- CNS: infections, frontal or temporal lobe dysfunction, head injuries,

3- Autoimmune diseases.

4- Electrolyte imbalance.

5- Endocrinopathies.

6- Metabolic disorders: hypoglycemia, porphyria, electrolyte imbalance.

C- Excitement due to drug intoxication or withdrawal

1- CNS stimulants: Amphetamines. Cocaine.

2- Opiates & CNS depressants: BDZ. Barbiturates. Alcohol

3- Hallucinogens & cannabinoids: LSD. Cannabis

D- Excitement due to non medical nor psychiatric disorders

1- Reaction to frustration: frustration situations may lead to hyperaggressiveness, destructiveness, & hostile attacks

2- Malingering: production of false or grossly exaggerated physical or psychological symptoms

Management of excitement & violence:

I- Verbal intervention:

- *Clinicians should attempt to calm the pt verbally:*

2- Physical intervention: Restraint & Seclusion:

- performed by at least five persons-There should be a specific plan e.g. Each taking one limb, parenteral sedatives after
- restraining Nursing observation every 15 min, remove restraints in presence of adequate number of staff.

3-Pharmacological intervention:

	Parental Unit dose	Side effects & complications
<u>I-Neuroleptics</u>		
<i>a-High potency</i>		
Haloperidol (haldol 5mg/ml)	5-10 mg/6 hr	1- Dystonia, akathesia, parkinsonian symptoms 2- Sedation anticholinergic symptoms, orthostatic hypotension, painful injection site.
Thioxanthenes (Clopixol Acuphase 100 mg amp)	100 mg/3 days IM	
<i>b-Low potency</i>		
Chlorpromazine 25mg/ml	25-50 mg IM/6 hr	3- Rare complications: laryngeal edema, neuroleptic malignant syndrome, drug induced catatonia, behavioral toxicity.
Promazine vial	25 mg IM/6 hr	
<u>II-Antianxiety</u>		
Diazepam 10 mg/2 ml	5-10 mg IV	Sedation potentiates CNS depressants, respiratory depression, paradoxical effect
<u>III-Hypnotics</u>		
Na Amytal	2.5 or 5% solution IV – 1 cc/min	Potentiates CNS depressants, respiratory depression, bronchospasm, laryngospasm

2- Dealing with suicidal patients:

Clinical presentation:

- 1- **Suicidal behavior:** ingestion of drugs, slashing wrist, burning, shooting, jumping
- 2- **Suicidal ideation & thoughts**

Causes:



- | | |
|---------------------------|-------------------------------|
| 3- Schizophrenia | 6- Personality disorder |
| 4- Organic brain syndrome | 7- Medical illness |
| 5- Panic disorder | 8- Non-psychiatric disorders. |

Management:

I- General rules:

- 1- Take all suicide threats seriously
- 2- The patient must be approached in an empathetic manner
- 3- Physicians must remain calm & uncritical
- 4- Obtain information from family members or friends
- 5- Ask the patient about suicide in privacy
- 6- Special nursing to protect the patient; do not allow sharp instruments

II- ICU admission if needed

III- Management of complications:

IV- Assessment of mental state

History: recent stressful event,

Past history of medical illness, psychiatric disorder or positive family history.

V- Referral to psychiatrist to treat the cause

3- Dealing with victims of acute stress: (Rape Assault, Disasters)

Management

History & examination:

- 1- Medical history, Physical examination to detect & document evidence of injuries,
- 2- Mental status examination

Investigations: radiological ...etc

Treatment

- 1- Physical ttt of injuries
- 2- Psychological: reassurance
- 3- Pharmacological ttt by hypnotosedatives
- 4- Referral to a psychiatrist if there is feeling of depression or post traumatic stress disorder if suspected.

4- Dealing with drug related emergencies (acute intoxication or withdrawal)

Clinical presentation:

- 1- ***Circulatory failure.*** Stimulants. Hypnotics, Alcohol



- 2- **Respiratory failure**. ARDS & inhalation pneumonia: Opiates. Barbiturates.
- 3- **Myosis**. opiates overdose
- 4- **Mydriasis**: anticholinergic, antidepressants, hallucinogens, stimulants
- 5- **Hyperthermia**. alcohol, stimulants, neuroleptic malignant syndrome
- 6- **Seizures**. overdose of alcohol & cannabis, withdrawal of BDZ, barbiturates & alcohol
- 7- **Asitation** . excitement: overdose of alcohol A hallucinogens, withdrawal of BDZ, BARB & alcohol.
- 8- **Acute dystonic reaction** side effect of neuroleptics
- 9- **Abdominal distention. urinary retention**: anticholinergics. antidepressants, antiparkinsonians
- 10- **Hypertensive encephalopathy** cheese reaction with MAOI
- 11- **Encephalopathy & tremors**: Lithium encephalopathy)

Investigations:

Laboratory. urine screen & serum levels of the drug

Other investigations should be done according to the clinical condition

Management

- Forced diuresis
- Hemodialysis if the drug is dialyzable
- Steroids IV or IM if needed
- Specific ttt according to the condition:
 - **Opiates**. Narcan 2 mg IV to be repeated until the pupil becomes dilated
 - **BDZ**. give Flumazenil amp as IV injection
 - **Lithium intoxication**. give Na Bicarbonate , Aminophyline & mannitol, Hemodialysis is next
 - **Torsion dystonia**. give diazepam IV / infusion, coffee enema , or Akinton injection followed by antiparkinsonian oral drugs & oral diazepam.
 - **Neuroleptic malignant syndrome**. Cold bath, ice enema. Dantrolene injection IV, bromocryptine
 - **Cheese reaction**: phentolamine IV, lasix IM & chlorpromazine IM
 - **Seizure**. give diazepam injection by IV drip
 - **Violence & excitement**. give neuroleptics (see management of violent patient)

5- Dealing with psychiatric disorder-related emergencies

• Panic attacks:

are episode of intense anxiety that come on suddenly, rise rapidly to the maximum intensity with an overwhelming sense of dread or terror associated

with tachycardia, sweating & dyspnea.

- Post Traumatic stress disorder:

Extraordinary & psychologically traumatic event followed by re-experiencing the event

- Emergency management (for both panic & PTSD):

1- Reassurance

2- Short acting *BDZ*

3- Referral to a psychiatrist for proper management.

- Factitious & malingering

- Conversion/Dissociative disorder

- Others

Differential Diagnosis of acute excitement

- | | |
|------------------------|--------------------------|
| - Head injury | - Hepatic encephalopathy |
| - Hypoglycemia | - Catatonic exc. |
| - CNS stimulant | - Manic exc. |
| - Agitative depression | - Drug withdrawal |
| - Alcoholism | |

Personality Disorders

Personality denotes characteristic ways of thinking, feeling behaving & reacting to the environment, when this psychological signature strikes a useful balance between consistency & adaptive flexibility, we speak of personality traits. A personality disorder is said to exist when a person chronically uses certain mechanisms of coping in an inappropriate & maladaptive fashion.

- Criteria for diagnosis
- Long history
- Recurrent maladaptive behavior
- Minimal anxiety to the person himself
- Major problems with others

1- Paranoid personality

Suspicious & hypersensitive to perceived slights & injuries , they believe that someone might harm them.

2- Schizoid personality

These persons are loners who seem to have little need for others. Sensitive and avoiding close relationships

3- Histrionic personality

Superficial relationships, there is an exaggerated expression of emotions. Dependent, dramatizing and attention seeking.

4- Antisocial personality

Antisocial behavior, does not learn from experience or punishment.

5- Compulsive or obsessive personality

Persons are preoccupied with rules , details - inflexible

6- Cyclothymic personality

Mood swings, fluctuating between elation and sadness

7- Inadequate personality

The person fails in emotional, social and occupational adjustment.

Treatment: psychotherapy & antidepressants & sedation may be used



Eating Disorders

Anorexia Nervosa

- Female during adolescence
- 5-10% in male
- Upper social class
- Hormonal change may be a factor but mostly try to weight loss so return normal after weight gain

Diagnostic criteria:

- 1- Weight loss 25% of BWT
- 2- Avoidance of high caloric food
- 3- Distortion of body image = the patient regards herself as fatty.
- 4- Amenorrhea

Treatment:

- 1- Psychotherapy
- 2- Educating the pt about the danger of starvation.
- 3- Observe the patient During meal & after lhrs

Bulimia Nervosa

- May be related to anorexia
- It is almost exclusively confined to women age older than nervosa

Diagnostic criteria :

- 1- Recurrent bouts of eating
- 2- Lack of self control during eating
- 3- self induced vomiting
- 4- Weight within m normal & normal menses

Complication of vomiting

- 1- Alkalosis → tetany
- 2- Prerenal failure
- 3- Liver impairment
- 4- Inhalation pneumonia

Treatment:

- 1- Psychotherapy
- 2- Behavioral therapy

Treatment in

Psychiatry

I. Psychotherapy:

Supportive psychotherapy

There are many schools but the essential features of such lines are:

1. Personal discussion i.e. changing or influencing ideas or emotions & exploration of mental conflicts & stresses.
2. Establishment of an emotional relationship with the patient
3. Minimize or prevent deterioration and relapse
4. Help patient to cope with problems

A- Individual psychotherapy:

B- Group psychotherapy

It is performed in groups ranging from 5-15 pts The aim is to give support stimulation

Psychoanalysis:

It is based on that mental illness, especially neurosis character disorders result from unconscious conflict around the relation between the child & his parents *between* age 3-6 yrs

Behavioral therapy

This is based on the fact that neurotic symptoms are learned patterns of behavior. If we can re-educate the patient to new styles of situation, we may control this abnormal conditioned reflex .

Various lines of behavior therapy include:

1- Aversion therapy

The aim is to associate either mentally or physically certain disorders with unpleasant physical symptoms such as *apomorphine, cmtabiise* with alcohol

2- Positive conditioning:

e.g. in nocturnal enuresis, a bell to wake the child when the bladder is full

3-Flooding:

exposure of the pt to the most dreadful situation for up to one hour during the use of sedative.

4-Bio feedback therapy:

can be done by EMG for controlling tension, spasm.

Cognitive therapy used in depression

II- Electrical ttt [ECT (Electroconvulsive therapy)]

It is a sort of brain synchronization therapy (BST), based on regulation of the dysregulated receptors using electrical impulses.

Indications:

- 1- Severe depressive states
- 2- Schizophrenia, especially the catatonic type.
- 3- High suicidal risk when quick response is needed
- 4- Failure to respond to *antidepressants*
- 5- Elderly when tricyclic antidepressants may be unsafe
- 6- Depressive stupor

Technique

The pt may need from 6-12 sessions given twice/wk. The mode of action by possible stimulation of the hypothalamus increasing the brain amines. The risk are minimal but a memory disorder for recent events may occur for a period of 4 wks usually we used thiopentone and muscle relaxant during the procedure.

Contraindications

- Recent myocardial infarction,
- Chest infection,
- Increase ICT,
- Cerebral hge

Pharmacological Agents

1-Benzodiazepines

They act on the benzodiazepine site on GABA receptors → potentiation of action of GABA (inhibitory neurotransmitter)

Classification of benzodiazepines

1. Short acting:
 - Alprazolam (xanax 0.25-0.5 mg/D)
 - Lorazepam (Ativan 1-2 mg/D)
2. Intermediate acting:
 - Diazepam (valium 5-10 mg tab)
 - Bromazepam (lexotanil 1.5-3 mg tab)
3. Long acting:
 - Clonazepam (rivotril 0.5-2 mg/tab)

Uses:

- Anxiety
- Antiepileptic IV
- Muscle relaxant
- Withdrawal of alcohol
- Hypotonic

Side effects

- Sedation
- Hang over (with long acting)
- Withdrawal symptoms with valium.

How can you use benzodiazepines correctly

- Short acting
- Intermittent use
- Used only in severe anxiety
- Short term use
- Lowest effective use

Problems of long term use of benzodiazepines

1. Tolerance
2. Dependence
3. Rebound effects especially rebound insomnia, so the rate of dose reduction should be very slowly.

2-Antidepressant drugs

they act through reuptake inhibition, inhibition of MAO enzyme, increase release or action on receptors.

a-MAOI

- They increase the biogenic amines e.g *parstelin (pamate + stelazine)* through inhibition of MAO enzyme.
- They can give effects within 5-7 days caution should be taken on giving MAOI with *tofranil, sympathomimetics* otherwise hypertensive crises occurs in about 5-10%

b- Tricyclic Antidepressants

(inhibit re-uptake, of amines NA, DA and 5HT)

Stimulant: Impiramine (tofranil) 5 - 200 mg/d

Sedative:

- *Amitriptyline (Trypizole)* 75-200 mg /d
- *Clomipramine (Anafranil)* 75-200mg /d

Side effects

- Anticholinergic (dryness of secretions, constipation, retention of urine, glaucoma)
- Postural hypertension (α_1 Blockade)
- Cardiac toxicity (arrhythmia)

c- SSRI Selective Serotonin Re-uptake Inhibitors

- *less cardiotoxic*
- *less sedative*
- *less anticholinergic*

Examples

- *Lustral((sertsatm€)* 50-150-mg/ d (50 mg tab)
- *Citalopram* 20-60 mg/d tab (*Cipram*) (20 mg tab)



- *Fluvoxamine (Faverin)* 100-200 mg/d (50 mg tab)
- *Fluoxetine (prozac)* (20 mg tab)

Side effects of SSRI

- *GIT disturbance*
- *Insomnia*
- *Tremors*
- *Delayed ejaculation*

3-Mood stabilizing

Uses:

- Bipolar disorders
- Resistant depression
- Schizo affective disorders
- Resistant schizophrenia

a-Lithium salts (Priadel)

- •Lithium carbonate 800-1200 mg/d.
- •It replace sodium in the neurons thus stabilizing membrane excitability
- •**Side effects are:** DI, tremors, Hypothyroidism

b-Carbamazepines (Tegretol)

- It is an anticonvulsant drug.
- Tegretol 600-1200 mg/D
- Na valproate (Depakine) can be used.

4-Antipsychotics

The conventional antipsychotic act through blocking dopamine receptors in the limbic & striatal systems. The new antipsychotic block dopamine receptors in limbic system and serotomergic receptors in frontal cortex.

a-Phenothiazines:

- *Dimethylamine e.g chlorpromazine (neurazine)* 600-1000 mg/d used in excited agitated schizophrenia, mania
- *Piperizine e.g. trifluoperazine (stelazine)* 15-30 mg/d, *fluphenazine (moditen)* 15-30 mg used in retarded schizophrenia
- •*Piperidine e.g melleril* 100-800 mg/d
- *Modecate 25 mg amp (long acting)*

b-Butyrophenones

e.g. *Haloperidol, safinace* 5-30 mg/d it is effective in controlling agitation, excitement

Side effects

- Sleepiness
- Hypotension
- Bone marrow depression
- Extrapryamidal e.g parkinsonism, Dystonia and akathesia, this can be avoid by anticholinergic drugs.
- Jaundice
- Impotence
- Hyperprolactinemin

c-Thioxanthenes

- Fluanxole 0.5-3 mg tab, 3-6 tab/D
- **Side effects** as phenothiazines

d-New antipsychotic

- Clozapine (leponex) 300-600 mg/D
- **Side effects:** weight gain, sexual problems

5-Beta Blockers

- Propranolol (Inderal) 30-60 mg/D
- Used in anxiety, aggression and tremors
- They decrease peripheral manifestations

Chronic fatigue syndrome (neuroasthenia)

Diagnosis

Symptoms

Major

- fatigue lasting >3-6m
- Disturbance of concentration

Minor

- initiating Viral like illness
- joint pain
- headache, dizziness
- myalgia
- abdominal pain
- sleep disorders

signs

- tender muscles or muscle weakness
- enlarged L.N or inflamed throat

Etiology → Unknown, several conditions are involved including infection & immune response to infection

Investigation → non specific

Treatment → sedative, antidepressant

Psychiatry case Taking History

1- Identifying data:

Male patient Named Aged from..... works as..... or unemployed
.....religion.....

2- Reason for referral:

- **Why?** → for ttt.
- **How?** → upon his request
→ against his will. [Importance of this → insight, compliance.]

3- C/O ((بالعربي))

- ايه اللي جابك المستشفى
- اكتب كلام المريض بالتفصيل حتى و لم يكن له معنى
- حاول توجيه بعض الأسئلة لتضيف معلومات مثل (ضلالات، هلاوس، وساوس، مخاوف، عدم ترابط الكلام)
- حاول إبراز هذه الأشياء خصوصاً لو أنت لاحظتها بنفسك

4- HPI

- Onset....., Course, Duration of symptoms
- **Significance** → progressive course → schizophrenia
→ regressive or periodic → manic D. psychosis.
- لذلك أسأل عن الآتي
- آخر مرة كان سليم
- هل المريض بيزيد أم يقل
- هل هناك فترة رجع فيها المريض لحالته الطبيعية e.g. in manic d. psychosis
- Did the pt return to the **premorbid personality**
- **History of hospitalization or drug intake** (also ETC, response. compliance)

5- Associated impairments.

- **Biological signs of depression**
 - Decrease weight
 - Insomnia
 - Amenorrhea
- **Habits change (sleep, eating, tea, ...)**
- **Social relationships (work, home, relatives)**

6- Family History

- a-Father, b-mother, c-relatives
- ask about (personal H., illness or similar illness (صرع، إدمان، عصاب)، & relation with the patient)

7- Personal History, (or past personal history)

- **Perinatal**
- **Neurotic traits e.g.** التبول اللاإرادي، العصبية الشديدة، الكوابيس، المشي أثناء النوم، الفزع
- **School** مستواه الدراسي و نسبة النجاح، سنوات الرسوب و السبب
- **Adolescence** → e.g. sexual fantasies or practices
- **Adulthood Work**
 - Military service Marriage
 - Duration of engagement
 - His reaction towards the birth of his children

8- Past History

Psychiatric

- Inpatient (no of admission)
- Outpatient (name of doctors followed him up & for how long)
- Drugs
- ECT

Medical

- Fever (meningitis, encephal.)
- Epilepsy

9- Social atmosphere بيعيش مع مين، الدخل الشهري

10- Antisocial behavior شجار بالمنزل ، سجن، محاكم

11- Personality before illness

- a- Attitude to self e.g. confident or not.
- b- Attitude to others e.g. social withdrawal.
- c- Hobbies
- d- Reaction to stress (verbal, physical,)

Psychiatric Examination

1- Appearance

- Clean or not
- Clothes tidy or not

2- Behavior (calm, agitated)

3- Talk

- Quantity → normal, talkative or induced.
- Quality → e.g. coherence, concrete (أعطى له مثل يفسره)

4- Mood

- Reactive (normal)
- Depressed
- Euphoric

5- Pre-occupation ايه اللي شاغل تفكيرك

6- Thought disorders (delusions, obsessions)

7- Perceptual disorders

- Hallucination (Visual → organic, auditory → schiz., tactile → cocaineism)
- Illusions
- Depersonalization (يخس أنه مش هو، يبص فى المرايا)

8- Cognitive functions:

- Orientation (T.P.P) (time, place & persons)
- Attention (أنادى عليه ينتبه)
- Concentration i.e. to maintain attention (أسئلة فى عمليات الجمع و الطرح)
- Memory
 - Immediate (جملة و يعيدها)



- جملة و يعيدها بعد خمس دقائق Recent
- أسماء الرؤساء القدامى ، تواريخ ميلاد أولاده Remote
- مستواه الدراسى ، الوظيفة ، النمو Intelligence

9- Insight هل تعتقد أن لديك مشاكل ، هل أنت فى حاجة إلى العلاج

10- Physical examination & local medical ex, & neurological ex,

11- Investigations:

- a- Social → more information about the patient From his family.
- b- Psychic → psychometry (IQ testing)
- c- Biological (T3&T4, Cortisone, VMA,...)
- d- Imaging (CT, MRI)

تم بحمد الله

T.me/Altebfamily